



CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. Temporary substitutes in a licensed day care home or licensed group day care home are not required to obtain a health assessment. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this KDHE form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Name of the facility (exactly as stated on the license) _____ License # _____

Street Address _____ City _____ Zip Code _____ County _____

Check type of child care facility:

- ☐ Licensed Day Care Home ☐ Child Care Center ☐ Preschool
☐ Group Day Care Home ☐ School Age Program ☐ Head Start Center

Name of Provider/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.

- | | <u>Yes</u> | <u>No</u> |
|---------------------------------------------------------------------------------------------|------------|-----------|
| 1. Do you see a physician regularly for any health condition? | _____ | _____ |
| 2. Are you taking any medication regularly? | _____ | _____ |
| 3. Have you had any surgery in the past 3 years? | _____ | _____ |
| 4. Do you have any handicapping conditions which might interfere with the care of children? | _____ | _____ |
| 5. Do you have any chronic illness conditions such as: | | |

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Headaches	_____	_____	Cancer	_____	_____	Alcoholism	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____	Arthritis	_____	_____
High Blood Pressure	_____	_____	Convulsions	_____	_____	Liver Disease	_____	_____
Lung Disease	_____	_____	Mental Illness	_____	_____	Other	_____	_____

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments.

Date (MM/DD/YYYY)

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments.

Date (MM/DD/YYYY)

Record results of TB test or attach results to this form.

Negative tuberculin test _____ or negative chest x-ray _____ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____
Licensed Physician/Nurse Signature or Health Department

Date (MM/DD/YYYY)